

**(COMPANY NAME)**

Outline of Medicare Supplement Coverage - Cover Page:  
Benefit Plan(s) \_\_\_\_\_ (Insert letter(s) of plan(s) being offered)

Medicare supplement insurance can be sold in only ten standard plans plus two high deductible plans. This chart shows the benefits included in each plan. Every company must make available Plan A. Some plans may not be available in your state.

**BASIC BENEFITS:** Included in All Plans.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses), or, in the case of hospital outpatient department services under a prospective payment system, applicable copayments.

Blood: First three pints of blood each year.

A	B	C	D	E	F*	G	H	I	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drugs (\$1,250 Limit)	Basic Drugs (\$1,250 Limit)	Extended Drugs (\$3,000 Limit)
				Preventive Care					Preventive Care

\* Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same or offer the same benefits as plans F and J after one has paid a calendar year [\$1,500] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are [\$1,500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but does not include, in plan J, the plan's separate prescription drug deductible or, in plans F and J, the plan's separate foreign travel emergency deductible.

**PREMIUM INFORMATION** (Boldface Type)

We (insert issuer's name) can only raise your premium if we raise the premium for all policies like yours in this State. (If the premium is based on the increasing age of the insured, include information when premiums will change).

**DISCLOSURES** (Boldface Type)

Use this outline to compare benefits and premiums among policies.

**READ YOUR POLICY VERY CAREFULLY** (Boldface Type)

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance policy.

**RIGHT TO RETURN POLICY** (Boldface Type)

If you find that you are not satisfied with your policy, you may return it to (insert issuer's address). If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

**POLICY REPLACEMENT** (Boldface Type)

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

**NOTICE** (Boldface Type)

This policy may not fully cover all of your medical costs.

(for agents:)

Neither (insert company's name) nor its agents are connected with Medicare.

(for direct response:)

(insert company's name) is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare and You" for more details.

**COMPLETE ANSWERS ARE VERY IMPORTANT** (Boldface Type)

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. (If the policy or certificate is guaranteed issue, this paragraph need not appear.)

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

(Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to section 16-12-6(d) of this chapter.)

(Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.)

## PLAN A

### MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies. First 60 days 61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days --Beyond the Additional 365 days	All but [\$764]† All but [\$191]† a day All but [\$382]† a day \$0 \$0	\$0 [\$191]†† a day [\$382]†† a day 100% of Medicare Eligible Expenses \$0	[\$764]†† (Part A Deductible) \$0 \$0 \$0 All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$95.50]† a day \$0	\$0 \$0 \$0	\$0 Up to [\$95.50]†† a day All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

† Medicare redetermines deductibles on an annual basis.

†† Plan payments and your payments are adjusted annually based on medicare deductibles.



## PLAN A

### MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

\*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES -</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0  Generally 80%  \$0	\$0  Generally 20%  \$0	\$100 (Part B Deductible)  \$0  All Costs
<b>BLOOD</b> First 3 pints Next \$100 Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

## PARTS A & B

<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100%  \$0 80%	\$0  \$0 20%	\$0  \$100 (Part B Deductible) \$0
---	------------------------	-----------------------	---



## PLAN B

### MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies. First 60 days 61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days --Beyond the Additional 365 days	All but [\$764]† All but [\$191]† a day All but [\$382]† a day \$0 \$0	[\$764]†† (Part A Deductible) [\$191]†† a day [\$382]†† a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0 All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$95.50]† a day \$0	\$0 \$0 \$0	\$0 Up to [\$95.50]†† a day All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

† Medicare redetermines deductibles on an annual basis.

†† Plan payments and your payments are adjusted annually based on medicare deductibles.





## PLAN B

### MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

\*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES -</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0  Generally 80%  \$0	\$0  Generally 20%  \$0	\$100 (Part B Deductible)  \$0  All Costs
<b>BLOOD</b> First 3 pints Next \$100 Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

### PARTS A & B

<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100%  \$0 80%	\$0  \$0 20%	\$0  \$100 (Part B Deductible) \$0
---	------------------------	-----------------------	---



## PLAN C

### MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies. First 60 days 61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days --Beyond the Additional 365 days	All but [\$764]† All but [\$191]† a day All but [\$382]† a day \$0 \$0	[\$764]†† (Part A Deductible) [\$191]†† a day [\$382]†† a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0 All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$95.50]† a day \$0	\$0 Up to [\$95.50]†† a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

† Medicare redetermines deductibles on an annual basis.

†† Plan payments and your payments are adjusted annually based on medicare deductibles.



## PLAN C

### MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

\*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES -</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	      \$0  Generally 80%  \$0	      \$100 (Part B Deductible)  Generally 20%  \$0	      \$0  \$0  All Costs
<b>BLOOD</b> First 3 pints Next \$100 Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All Costs \$100 (Part B Deductible) 20%	 \$0 \$0 \$0
<b>CLINICAL LABORATORY            SERVICES - BLOOD TESTS            FOR DIAGNOSTIC SERVICES</b>	 100%	 \$0	 \$0

### PARTS A & B

<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	      100%  \$0  80%	      \$0  \$100 (Part B Deductible)  20%	      \$0  \$0  \$0
--	--	---	---

### OTHER BENEFITS - NOT COVERED BY MEDICARE

<b>FOREIGN TRAVEL -</b> NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA. First \$250 each calendar year Remainder of Charges	      \$0 \$0	      \$0 80% to a lifetime maximum benefit of \$50,000	      \$250 20% and amounts over the \$50,000 lifetime maximum
---	------------------------------------	---	---



## PLAN D

### MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies. First 60 days 61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days --Beyond the Additional 365 days	All but [\$764]† All but [\$191]† a day All but [\$382]† a day \$0 \$0	[\$764]†† (Part A Deductible) [\$191]†† a day [\$382]†† a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0 All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$95.50]† a day \$0	\$0 Up to [\$95.50]†† a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

† Medicare redetermines deductibles on an annual basis.

†† Plan payments and your payments are adjusted annually based on medicare deductibles.





## PLAN D

### MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

\*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES -</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	      \$0  Generally 80%  \$0	      \$0  Generally 20%  \$0	      \$100 (Part B Deductible)  \$0  All Costs
<b>BLOOD</b> First 3 pints Next \$100 Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All Costs \$0 20%	 \$0 \$100 (Part B Deductible) \$0
<b>CLINICAL LABORATORY            SERVICES - BLOOD TESTS            FOR DIAGNOSTIC SERVICES</b>	 100%	 \$0	 \$0

(continued)



**PLAN D (continued)**

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE -</b> <b>MEDICARE APPROVED</b> <b>SERVICES</b> --Medically necessary skilled care services and medical supplies --Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	   100%   \$0  80%	   \$0  \$0  20%	   \$0  \$100 (Part B Deductible)  \$0
<b>AT HOME RECOVERY</b> <b>SERVICES - NOT COVERED BY</b> <b>MEDICARE</b> Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan --Benefit for each visit  --Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)  --Calendar year maximum	   \$0  \$0  \$0	   Actual Charges to \$40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week  \$1,600	   Balance

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL -</b> <b>NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	   \$0 \$0	   \$0 80% to a lifetime maximum benefit of \$50,000	   \$250 20% and amounts over the \$50,000 lifetime maximum
---	------------------------	---	---



## PLAN E

### MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies. First 60 days 61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days --Beyond the Additional 365 days	All but [\$764]† All but [\$191]† a day All but [\$382]† a day \$0 \$0	[\$764]†† (Part A Deductible) [\$191]†† a day [\$382]†† a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0 All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$95.50]† a day \$0	\$0 Up to [\$95.50]†† a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

† Medicare redetermines deductibles on an annual basis.

†† Plan payments and your payments are adjusted annually based on medicare deductibles.



## PLAN E

### MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

\*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES -</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	      \$0 Generally 80% \$0	      \$0 Generally 20% \$0	      \$100 (Part B Deductible) \$0 All Costs
<b>BLOOD</b> First 3 pints Next \$100 Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All Costs \$0 20%	 \$0 \$100 (Part B Deductible) \$0
<b>CLINICAL LABORATORY            SERVICES - BLOOD TESTS            FOR DIAGNOSTIC SERVICES</b>	 100%	 \$0	 \$0

### PARTS A & B

<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	      100% \$0 80%	      \$0 \$0 20%	      \$0 \$100 (Part B Deductible) \$0
--	--	---	---

(continued)





**PLAN E** (continued)

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL -</b> NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
<b>***PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE</b> Annual physical and preventive tests and services such as fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional Charges	\$0 \$0	\$120 \$0	\$0 All Costs

\*\*\*Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.



## PLAN F OR HIGH DEDUCTIBLE PLAN F

### MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\*This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [\$1,500] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$1,500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$1,500 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$1,500 DEDUCTIBLE,** YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies. First 60 days 61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days  --Beyond the Additional 365 days	All but [\$764]† All but [\$191]† a day  All but [\$382]† a day  \$0  \$0	[\$764]†† (Part A Deductible) [\$191]†† a day  [\$382]†† a day  100% of Medicare Eligible Expenses  \$0	\$0 \$0  \$0  \$0  All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital. First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$95.50]† a day \$0	\$0 Up to [\$95.50]†† a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

(Continued)

† Medicare redetermines deductibles on an annual basis.

†† Plan payments and your payments are adjusted annually based on medicare deductibles.



## PLAN F OR HIGH DEDUCTIBLE PLAN F

### MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

\*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

\*\*This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [\$1,500] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$1,500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$1,500 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$1,500 DEDUCTIBLE,** YOU PAY
<b>MEDICAL EXPENSES -</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0  Generally 80%  \$0	\$100 (Part B Deductible)  Generally 20%  100%	\$0  \$0  \$0
<b>BLOOD</b> First 3 pints Next \$100 Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$100 (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY            SERVICES - BLOOD TESTS            FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

### PARTS A & B

<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First \$100 of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	100%  \$0 80%	\$0  \$100 (Part B Deductible) 20%	\$0  \$0 \$0
---	------------------------	---	-----------------------

### OTHER BENEFITS - NOT COVERED BY MEDICARE

<b>FOREIGN TRAVEL -</b> NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA. First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
---	------------	---	---



## PLAN G

### MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies. First 60 days 61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days --Beyond the Additional 365 days	All but [\$764]† All but [\$191]† a day All but [\$382]† a day \$0 \$0	[\$764]†† (Part A Deductible) [\$191]†† a day [\$382]†† a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0 All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$95.50]† a day \$0	\$0 Up to [\$95.50]†† a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

† Medicare redetermines deductibles on an annual basis.

†† Plan payments and your payments are adjusted annually based on medicare deductibles.

## PLAN G

### MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

\*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES</b> - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	 \$0 Generally 80% \$0	 \$0 Generally 20% 80%	 \$100 (Part B Deductible) \$0 20%
<b>BLOOD</b> First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All Costs \$0 20%	 \$0 \$100 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)



**PLAN G (continued)**

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE -</b> MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100%   \$0  80%	\$0   \$0  20%	\$0   \$100 (Part B Deductible)  \$0
<b>AT HOME RECOVERY</b> <b>SERVICES - NOT COVERED BY</b> <b>MEDICARE</b> Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan --Benefit for each visit  --Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)  --Calendar year maximum	\$0  \$0  \$0	Actual Charges to \$40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week  \$1,600	Balance

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL -</b> NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
--	------------	---	---

## PLAN H

### MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies. First 60 days 61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days --Beyond the Additional 365 days	All but [\$764]† All but [\$191]† a day  All but [\$382]† a day  \$0  \$0	[\$764]†† (Part A Deductible) [\$191]†† a day  [\$382]†† a day  100% of Medicare Eligible Expenses  \$0	\$0 \$0  \$0  \$0  All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$95.50]† a day \$0	\$0 Up to [\$95.50]†† a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

† Medicare redetermines deductibles on an annual basis.

†† Plan payments and your payments are adjusted annually based on medicare deductibles.

## PLAN H

### MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

\*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES -</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	       \$0 Generally 80% \$0	       \$0 Generally 20% \$0	       \$100 (Part B Deductible) \$0 All Costs
<b>BLOOD</b> First 3 pints Next \$100 Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All Costs \$0 20%	 \$0 \$100 (Part B Deductible) \$0
<b>CLINICAL LABORATORY            SERVICES - BLOOD TESTS            FOR DIAGNOSTIC SERVICES</b>	 100%	 \$0	 \$0

### PARTS A & B

<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	      100% \$0 80%	      \$0 \$0 20%	      \$0 \$100 (Part B Deductible) \$0
--	--	---	---

(continued)

**PLAN H** (continued)

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL -</b> NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
<b>BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE</b> First \$250 each calendar year Next \$2,500 each calendar year  Over \$2,500 each calendar year	\$0 \$0  \$0	\$0 50% -- \$1,250 calendar year maximum benefit \$0	\$250 50%  All Costs

## PLAN I

### MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies. First 60 days 61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days --Beyond the Additional 365 days	All but [\$764]† All but [\$191]† a day  All but [\$382]† a day  \$0  \$0	[\$764]†† (Part A Deductible) [\$191]†† a day  [\$382]†† a day  100% of Medicare Eligible Expenses  \$0	\$0 \$0  \$0  \$0  All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$95.50]† a day \$0	\$0 Up to [\$95.50]†† a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

† Medicare redetermines deductibles on an annual basis.

†† Plan payments and your payments are adjusted annually based on medicare deductibles.

## PLAN I

### MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

\*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES</b> - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	 \$0 Generally 80% \$0	 \$0 Generally 20% 100%	 \$100 (Part B Deductible) \$0 \$0
<b>BLOOD</b> First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All Costs \$0 20%	 \$0 \$100 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

**PLAN I (continued)**

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE -</b> MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100%   \$0  80%	\$0   \$0  20%	\$0   \$100 (Part B Deductible)  \$0
<b>AT HOME RECOVERY</b> <b>SERVICES - NOT COVERED BY</b> <b>MEDICARE</b> Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan --Benefit for each visit  --Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)  --Calendar year maximum	\$0  \$0  \$0	Actual Charges to \$40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week  \$1,600	Balance

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL -</b> NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
<b>BASIC OUTPATIENT</b> <b>PRESCRIPTION DRUGS - NOT</b> <b>COVERED BY MEDICARE</b> First \$250 each calendar year Next \$2,500 each calendar year  Over \$2,500 each calendar year	\$0 \$0 \$0	\$0 50% -- \$1,250 calendar year maximum benefit \$0	\$250 50%  All Costs

## PLAN J OR HIGH DEDUCTIBLE PLAN J

### MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\*This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [\$1,500] deductible. Benefits from the high deductible Plan J will not begin until out-of-pocket expenses are [\$1,500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$1,500 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$1,500 DEDUCTIBLE,** YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies. First 60 days 61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days  --Beyond the Additional 365 days	All but [\$764]† All but [\$191]† a day  All but [\$382]† a day  \$0  \$0	[\$764]†† (Part A Deductible) [\$191]†† a day  [\$382]†† a day  100% of Medicare Eligible Expenses  \$0	\$0 \$0  \$0  \$0  All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital. First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$95.50]† a day \$0	\$0 Up to [\$95.50]†† a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

† Medicare redetermines deductibles on an annual basis.

†† Plan payments and your payments are adjusted annually based on medicare deductibles.





## PLAN J OR HIGH DEDUCTIBLE PLAN J

### MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

\*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

\*\*This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [\$1,500] deductible. Benefits from the high deductible Plan J will not begin until out-of-pocket expenses are [\$1,500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$1,500 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$1,500 DEDUCTIBLE,** YOU PAY
<b>MEDICAL EXPENSES -</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0  Generally 80%  \$0	\$100 (Part B Deductible)  Generally 20%  100%	\$0  \$0  \$0
<b>BLOOD</b> First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$100 (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY            SERVICES - BLOOD TESTS            FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

### PARTS A & B

<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100%  \$0 80%	\$0  \$100 (Part B Deductible) 20%	\$0  \$0 \$0
--	------------------------	---	-----------------------

(continued)



**PARTS A & B (continued)**

### OTHER BENEFITS - NOT COVERED BY MEDICARE

\*\*\*Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

**HCFA DEDUCTIBLES FOR PLANS F AND J**Calendar Year BeginningFederal Register

January 1, 1999	\$1,500	
January 1, 2000	\$1,530	Monday, April 10, 2000
January 1, 2001	\$1,580	Thursday, December 21, 2000
January 1, 2002	\$1,620	Friday, December 28, 2001

